



Fertile Ground Wellness Center
1091 S. Gaylord St.
Denver, CO 80209

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fertilegroundwellnesscenter@gmail.com

New Patient Intake Form

Name _____ Date of birth ____/____/____ Age _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Alternate Phone _____

Email address _____

I would like to opt out of receiving Fertile Ground newsletters and other email

Employer _____ Phone _____

Occupation _____

Marital Status _____ Number of Children _____

Personal Physician _____ Phone _____

Emergency Contact _____ Phone _____

Who can we thank for referring you to our office? _____

Clinic Policy

Your appointment time has been specifically reserved for you. If you need to cancel an appointment, we ask that you give 24 hours notice. If less than 24 hours notice is given for a cancelled appointment or an appointment is missed, we reserve the right to bill you for the full amount of the appointment. If you are late for an appointment, we may have to shorten your appointment time accordingly in order to be prompt and prepared for upcoming patients. Please understand that this policy is in place because we do our best to respect you and your time and we expect the same from you in return.

Payment for services will be due at the time of the visit. Cash, checks, and credit cards are acceptable forms of payment. Credit cards are processed through Therapy Partner. Upon your request, an invoice with procedure codes and diagnosis codes can be printed for you to submit to your insurance company. However, Fertile Ground cannot be responsible for the insurance company's failure to reimburse.

Signature

Please indicate your understanding and acceptance of these policies by signing below:

Signed _____ Date _____

HIPAA Form

Please check and initial the following to indicate you have read and understand the information in these forms and accept the policies therein: *Initials*

HIPAA Form & Protecting Your Health Information _____